

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/10/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BRIDGE AT MONTEAGLE (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 26 SECOND STREET MONTEAGLE, TN 37356
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>An annual licensure survey and complaint investigation #30463 were completed on October 8-10, 2012. No deficiencies were cited with Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

Division of Health Care Facilities


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8500

WZJG11



10/24/12

If continuation sheet 1 of 1